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December 19, 2006

AGENDA ITEM 3

TO: MEMBERS OF THE HEALTH BENEFITS COMMITTEE

I. SUBJECT: First Reading – Update on Blue Shield of California's Exclusive Provider Organization and Direct Contract Counties

II. PROGRAM: Health Benefits

III. RECOMMENDATION: Information Only

IV. INTRODUCTION:

At the June 2006 Health Benefits Committee meeting, Blue Shield of California (Blue Shield) requested Board approval to modify its current Blue Shield Health Maintenance Organization (HMO) service area. This request resulted from the higher health care costs in thirteen Exclusive Provider Organization (EPO) and Direct Contract (DC) counties*. The CalPERS Board deferred the proposal to the 2008 rate renewal cycle and directed Blue Shield to communicate with and engage appropriate constituent groups and complete further analysis of its proposed alternatives. As such, this agenda item is a preliminary discussion in which Blue Shield will review the issues, present a summary of suggested options, and discuss next steps.

V. BACKGROUND:

As a result of its exclusive HMO network contract established in 2004, the CalPERS Blue Shield HMO network is a three-tier delivery system which includes:

- **6 EPO counties** (Colusa, El Dorado, Lake, Mendocino, Plumas, and Sierra) where health care is delivered much like that of a PPO plan – no primary care provider is selected or coordinates specialty referrals and diagnostics, and utilization management is limited primarily to inpatient hospital admissions. There is often only one hospital provider, which limits Blue

* Blue Shield proposed service area and benefit design alternatives for eight DC counties: Butte, El Dorado, Glenn, Mariposa, Napa, San Luis Obispo, San Mateo, and Sonoma, and to discontinue its HMO plan in five EPO counties: Colusa, Lake, Mendocino, Plumas, and Sierra.

Shield's ability to negotiate facility reimbursements. Therefore, these facilities tend to be significantly more expensive than the average. There is a limited physician specialty pool so consequently patients seek health care outside of the Blue Shield HMO network, opting into the Blue Shield PPO network.

- **10 DC counties** (Butte, Glenn, Mariposa, Merced, Napa, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, and Sonoma) where health care is delivered through a primary care provider. However, as with the EPO counties, some physician specialties are limited and hospital options are minimal, resulting in reimbursement costs greater than the average.

- **24 managed care counties** (Core HMO) where provider reimbursement agreements are largely based on capitation or per diem methodology, providing the incentive for providers to deliver health care services at the appropriate level and location.

During the past two years, Blue Shield has conducted focused analyses on health care cost drivers. These analyses indicate that both the EPO and DC counties have much higher health care costs and cost trends than the Core HMO counties. In comparison to the Core HMO counties, 2005 health care costs in the EPO counties were approximately 73 percent higher and the DC counties were approximately 25 percent higher. Likewise, in 2005, the health costs in EPO counties trended at 25 percent, the health costs in DC counties trended at 17 percent, and the health costs in Core HMO counties trended below 9 percent.

The mix of CalPERS Blue Shield enrollees between Core HMO and EPO/DC counties is compounding the impact of the EPO/DC costs on the Blue Shield premiums. In 2003, enrollees in the Core HMO comprised 89 percent of the CalPERS Blue Shield membership (406,000 total covered lives), and EPO/DC enrollees comprised 11 percent of the CalPERS Blue Shield membership (53,000 total covered lives). Over the past three years, driven in part by the cost impact of the EPO/DC counties, the Core HMO membership has decreased by 75,000 total covered lives (now representing 85% of the CalPERS Blue Shield membership) while the EPO/DC membership has increased by 5,000 total covered lives (now representing 15 percent of the CalPERS Blue Shield membership). This larger percentage of higher cost EPO/DC enrollees translates into higher overall premiums for CalPERS Blue Shield members.

In response to the Board's request, Blue Shield implemented Regional Councils aimed at providing transparency and education related to health care cost drivers in the relevant EPO and DC counties, sharing its recommendations for changes necessary to preserve a managed care model (HMO), and seeking support and assistance from employers and member organization leaders to implement such changes. Thus far, the Regional Councils are making progress toward limiting health care trends in these counties by having a positive impact on Blue Shield's negotiations with physician groups and hospitals.

VI. ANALYSIS:

Although the Regional Councils are having a positive impact, the cost of health care in the EPO and DC counties is so high that even with low or declining health care trends, the EPO/DC costs remain significantly above the Core HMO costs. To address the ongoing high cost issue in the EPO/DC counties, Blue Shield will be analyzing four options:

1. Discontinue coverage in some or all of the high cost counties
2. Implement a different benefit design in some or all of the high cost counties
3. Allow public agency rating factors to reflect actual costs
4. Develop a subsidy and annuitant loading program that requires all the CalPERS health plans to share in the high costs of these counties.

The scope of this analysis will include:

- Cost analysis for CalPERS Blue Shield total covered lives by county, detailing state versus public agency costs
- Potential disruption of members
- Potential change in member out-of-pocket costs, including premium and/or co-payments and deductibles, and
- Engagement of constituent groups as appropriate.

Blue Shield plans to provide the results of this detailed analysis at the February Health Benefits Committee meeting and in preparation, seeks input from the Board, staff, and constituents on this suggested approach and analysis.

Paul Markovich, Senior Vice President, Large Group Business Unit, Blue Shield of California will make a detailed presentation that will be distributed at the Health Benefits Committee meeting.

VII. STAFF RECOMMENDATION:

This is an information item.

VIII. STRATEGIC GOAL:

This item supports Goal X of the strategic plan which states, “Develop and administer quality, sustainable health benefits programs that are responsive to and valued by enrollees and employers.”

IX. RESULTS/COSTS:

This is an information item only.

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